CLIENT INFORMATION:
Child's First Name:_______________________________ Last Name:_______________________________
Preferred Name:________________________________ Gender: M / F
DOB:____ AGE:____________________________________
Home Address:____
Home Phone #:_______________________ Mom's Cell:_________________Dad's Cell:______________
Child resides with: Mom Dad Both Guardian Other:____
Name of School/DayCare/HomeSchool:_______________________________________Grade:_________

PARENT/GUARDIAN INFORMATION
Mother's First Name:__________________________ Last Name:________________________________
Father's First Name:___________________________ Last Name:________________________________
Alternate Address: (if child doesn't live with both parents):_______________________________________
Mother's Employer:___________________________ Father's Employer:___________________________
Sibling's Name: ______________________________ Age:______________________________________
Sibling's Name: ______________________________ Age:______________________________________
Sibling's Name: ______________________________ Age :______________________________________
Sibling's Name: ______________________________ Age :______________________________________

EMERGENCY CONTACT INFORMATION
Name: ____
Address:____
Home Phone #:________________________________ Cell #:_____________________________________
List anyone that your child can be released to besides the above listed Parents/Guardians:
Name: ____ Relationship:________________________________
Name:____Relationship:________________________________

SCHEDULING INFORMATION (check all available days and times)

Tuesdays:	Time:	3:00	4:00	5:00	6:00
Thursdays:	Time:	3:00	4:00	5:00	6:00
Saturdays:	Time:	10:00	11:00	12:00	

REFERRAL INFORMATION
Referring Physician: _________________________________ Phone: ______________________________
Address: ____
Pediatrician if different: ______________________________ Phone: ______________________________
Address: ____
Does your child have a diagnosis? ____
____

REASONS FOR REFERRAL (check all that apply)

- ○ Fine Motor Skills
- ○ Gross Motor Skills
- ○ Sensory Processing
- ○ Feeding/Nutrition
- ○ Play Skills
- ○ Social Skills
- ○ Attention/Focus
- ○ Self-Care
- ○ Visual/Perceptual Skills
- ○ Behavior/ABA
- ○ Social Skills Group
- ○ Deaf Education
- ○ Floor Time
- ○ Rainbow Dance

Any areas of concern relating to school?____________________
____
____
____
____
____
____
____

Anyone else in the family with similar difficulties?_____________
____
____
____
____
____

What goals do your family and your child want to achieve from therapy at Extra Steps?

1____
2____
3____
4____
5____

Did your child participate in an Early Intervention Program? YES | NO
If yes, which one? ____
Did/Does your child participate in an integrated Preschool Program? YES | NO
If yes, which one? ____

Is your child on an IEP at school? YES | NO
If so for what?____
____

Please indicate previous therapy your child has received:____________________________________
____
Please indicate current therapy your child is receiving: ____________________________________
____
What other evaluations/specialty services has your child received? (neuropsychology testing, psychological services, gastroenterology, MRI/EEG etc.)____
____

MAJOR MEDICAL ILLNESSES (check all that apply)

- Asthma
- Seizure
- Allergies Which Ones?____
- High Fevers
- Ear Infections How Many?____

Hospitalizations or Surgeries:
Reason: ____ Date: _________________
Reason: ____ Date: _________________
Reason: ____ Date: _________________

Medications:
Name: ________________________________ Purpose: _____________________________________
Name: ________________________________ Purpose: _____________________________________
Name: ________________________________ Purpose: _____________________________________
Name: ________________________________ Purpose: _____________________________________
Any precautions or important information regarding your child's medical needs? __________________
____
____
____

PREGNANCY, BIRTH & INFANCY HISTORY
Is your child adopted? (check one) YES / NO
Type of delivery: vaginal / C-section Weight:______Length:________Apgar Score:________
Complications/Medications during Pregnancy and/or Delivery:__________________________________
____
____
____

Feeding: (check one) Breast Bottle Both
Describe any difficulties:____
____
____

MAJOR MILESTONES- How old was your child when s/he:
Rolled Over: ____________ Sat Independent: _____________ Crawled on all 4's:____________
Stood Independently: _______ Cruised (holding on):___________ Walked independently: ______

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Comments: ____
____
____

PLAY SKILLS

Check the items that best describe your child's play:

- Plays alone
- Plays with other children
- Observes others playing rather than engaging
- Extreme seeker of movement
- Afraid of movement
- Poor safety awareness
- Avoids contact with sand/grass
- Seems very active
- Prefers sedentary play
- Does not notice when dirty
- Prefers indoor play
- Prefers being outside
- Does not like being dirty/sticky
- Avoids park equipment/or certain park equipment
- Plays on all park equipment

Concerns regarding your child's play:
____
____
____
____
____
____
____
____
____
____
____
____
____
____

SELF HELP SKILLS - Does your child complete the tasks below? (circle one)

Dressing	yes |	no |	with |	without assistance
Manage Fasteners (zipper, buttons, etc.)	yes |	no |	with |	without assistance
Tie Shoelaces	yes |	no |	with |	without assistance
Bathing	yes |	no |	with |	without assistance
Brush Teeth/Hair, etc.	yes |	no |	with |	without assistance
Toileting	yes |	no |	with |	without assistance
Wash Hands	yes |	no |	with |	without assistance

COMMUNICATION

What language/s are spoken at home? ____

What language/s does your child prefer to speak?______________________Understand?______________

What concerns do you have related to communication?____
____
____

Date of last hearing exam?____

Has your child ever seen an audiologist?____

How does your child communicate? *(check all that apply)*

Gestures   Pointing   Vocalizations/Babbling   PECS   Communication Device
Single Words   Two Word Phrases   Full Sentences (3+ words)

Age at first word? _____ Age at first sentence? _______ Is dysfluency a concern? ____________

Are there things your child does not seem to hear? Yes | No
Did your child acquire speech and then stop talking? Yes | No
How much of your child's speech do you understand? ____
How much of your child's speech do other adults understand? __________________________________

FEEDING

Are eating/feeding/or digestion a concern for your child? (check one): Yes | No

Does your child:

Eat a variety of foods?	Yes |	No
Stuff his/her mouth?	Yes |	No
Sit through a meal?	Yes |	No
Have regular bowel and bladder habits?	Yes |	No
Hiccup or burp frequently?	Yes |	No
Have frequent stomach discomfort?	Yes |	No
Have a special diet/food restrictions?	Yes |	No
Vegetarian?	Yes |	No
Gluten Free / Casein Free?	Yes |	No

Diary Free? Yes | No Soy Free? Yes | No
Food Allergies? Yes | No If so what? ____
Food Intolerances? Yes | No If so what? ____

Does your child show a particular **preference or avoidance** for:
Textures/Consistences: Yes | No Temperatures: Yes | No Tastes: Yes | No
Type of Food (carbs, sweets, proteins, etc.) Yes | No Describe:_________________________
____

Has your child had difficulty with:
Chewing: Yes | No Choking: Yes | No Swallowing: Yes | No
Sucking: Yes | No
Describe: ____
____

Is your child able to complete the following?

Finger Feed:	Yes |	No |	With |	Without	Assistance
Spoon/Fork Feed:	Yes |	No |	With |	Without	Assistance
Drink from a Bottle:	Yes |	No |	With |	Without	Assistance
Drink from a Sippy Cup:	Yes |	No |	With |	Without	Assistance
Drink from an Open Cup:	Yes |	No |	With |	Without	Assistance

SLEEPING (check one)

Does your child have unusual sleeping habits?	Yes |	No
Does your child go to bed with a bottle or sippy cup?	Yes |	No
Can your child fall asleep independently?	Yes |	No
Does your child sleep by him/herself or co-sleep?	Yes |	No
Does your child sleep through the night?	Yes |	No
Does your child have nightmares/night terrors?	Yes |	No
Does your child sleep walk?	Yes |	No
Do you have concerns about your child's sleeping habits?	Yes |	No

Please Describe: ____
____
____
____

BEHAVIOR

Is behavior a concern? Yes | No

In which environments? (check all) home school peers stores playground

(other)____

Indicate the behaviors your child may exhibit: (check all that apply)

Hitting | Kicking | Anxiety | Biting | Screaming | Spitting | 'Over Active'

Self-injurious | Extreme Shyness | Lack of Eye Contact |

Other____

What interventions, if any, have been put into place to manage the behaviors? ____________________
____
____
____

Do others (teachers, babysitters, etc.) have difficulty managing these behaviors? ___________________
____
____

Please describe any additional concerns or questions with regard to any area of your child's development and overall functioning that you would like to discuss with your child's therapist.

____
____
____
____

Thank you for taking the time to complete this lengthy form. The information you have provided will assist your therapist to develop a treatment plan that will be specific to your child's individualized needs. Extra Steps is committed to providing the highest quality of therapeutic intervention to both your child and your family.

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